September 2017

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Recommended Citation

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DECISIONS TO FOREGO MEDICAL TREATMENT: THE PREFERRED MEDICAL, ETHICAL, AND LEGAL APPROACH

J. Stuart Showalter*

I. Introduction

The issues addressed in this Article are among the most difficult our legal system will face in the coming years. They are not simply questions of statutory interpretation or an extension of case law. Rather, they involve questions of basic societal beliefs and are complicated all the more by the fact that there is not yet a clear consensus among members of society regarding them.

In many respects, the subjects addressed on the following pages are as basic (and as complex) as the two great social issues of our past—slavery and segregation—for they concern the inalienable human rights of life and freedom, and the dignity due to each person in the community of persons. As with slavery and segregation, the legal system will at once both lead and follow social attitudes. It will do so specifically with regard to such questions as: the nature of “death” and whether cessation of brain function means death of the person; the proper care and feeding of handicapped newborns; whether it is permissible to withhold treatment from irreversibly comatose patients; the so-called “right to die”; whether a proxy should be empowered to make decisions for a patient if the decision will result in the person’s death; the proper care and respect due elderly and incompetent patients; the propriety of do-not-resuscitate orders; and the role courts can and should play in all of the above.

This Article will begin with a brief summary of “brain death” cases and statutes—a summary that ends with the conclusion that consensus

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has in fact been reached on this issue.\(^1\) Next, there is a more detailed analysis of the law relating to decisions to terminate or withhold treatment emphasizing perceived methods for health care providers to avoid legal entanglements in making such decisions. Lastly, the Article suggests that in all these situations, physicians and the courts should rely more heavily on generally accepted medical and ethical standards (such as those enunciated in the recent President's Commission reports)\(^2\) rather than on purely legal principles.

II. Determination of Death\(^3\)

For many years, the definition of "death" used in the law was reflected in the following Black's Law Dictionary entry: "[t]he cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc."

Case law added another factor: "death occurs precisely when life ceases and does not occur until the heart stops beating and respiration ends. Death is not a continuing event and is an event that takes place at a precise time."

These definitions had been accurate and sufficient for many years, and, in most cases, today death continues to be determined by reliance on cessation of circulation and respiration. However, certain ambiguities in the traditional standard became apparent with the advent of cardiac transplantation surgery, for a heart that has not been beating for a period of time is worthless to its recipient, yet one that is still beating continues to be indispensable to its owner according to the standard definition. The 1972 case of Tucker v. Lower\(^4\) graphically illustrates this point.

Bruce Tucker died of head injuries sustained in a fall. Though heroic measures were attempted, he did not respond and was unable to breathe without the assistance of a respirator. Approximately 24 hours after he

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\(^1\) See generally President's Comm'n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Defining Death 1-5 (1981) [hereinafter cited as Defining Death].

\(^2\) The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, established by Act of Nov. 9, 1978, Pub. L. No. 95-622, § 301, 92 Stat. 3437 (codified as amended at 42 U.S.C. §§ 300v-300v-3 (1982)), is referred to in this Article as the "President's Commission."

\(^3\) Portions of the following are adapted, with permission, from A. Moraczewski & J. Showalter, Determination of Death (1982).


\(^6\) No. 2831 (Ct. Law & Eq., Va., May 25, 1972); see Fletcher, New Definitions of Death, PRISM, Jan. 1974, at 13; Comment, But When Did He Die?: Tucker v. Lower and the Brain Death Concept, 12 SAN DIEGO L. REV. 424, 424 (1975) (result represented departure from existing statutory definition of death but was logical extension of recent medical advances).
was injured, an electroencephalogram showed no cerebral activity. Tucker was removed from the respirator, and after five minutes during which he exhibited no spontaneous respiratory movements, was pronounced dead. Authorization had been obtained to transplant his heart into the chest of a patient who was dying of cardiac failure. (The authorization was obtained from the local medical examiner since no relative of Tucker's could be located. The diligence of the medical personnel's search for relatives was an issue in the trial that followed.) The transplant was accomplished, but the recipient died approximately one week later.

When Tucker's family was finally located, his brother filed a wrongful death claim for $1 million in a Richmond, Virginia court. At the close of the evidence in the ensuing trial, the judge instructed the jury:

you shall determine the time of death in this case by using the following definition of the nature of death. Death is a cessation of life. It is the ceasing to exist. Under the law, death is not continuing but occurs at a precise time . . . . In determining [it] you may consider the following elements . . . [among them] the time of complete and irreversible loss of all function of the brain.7

The jury took approximately one hour to return a verdict for the physicians absolving them of Tucker's death.

A similar case in California decided the issue in a criminal context. The court held that the defendant, the individual who had shot the victim, was the party responsible for the victim's death, not the physicians who had performed a heart transplant.8 Significantly, the judge decided as a matter of law, based on the concept of brain death, that the victim had died before the physicians had removed his heart. Thus, he instructed the jury: "since the deceased . . . was dead, before the removal of his heart, there was no issue of fact as to the cause of death."9

These cases recognize the nearly unanimous medical consensus that when the whole brain no longer functions, the person is clinically dead.10 Furthermore, they reinforce the concept that the determination of when death occurs is a medical judgment, not a legal one.11

7 Comment, supra note 6, at 424.
9 Friloux, supra note 8, at 15.
In the wake of these two early-1970's cases, courts in a number of jurisdictions took similar action and adopted the concept of brain death without benefit of legislation. In a homicide case in Arizona, that state's supreme court held that the proximate cause of death was not the removal of life support systems but the gunshot wounds that destroyed the victim's brain function. Similarly, in a Colorado child abuse case, the supreme court held:

[with advances, including resuscitative technology and organ transplants, the medical community has developed a more complete definition of death. There is a wealth of material describing these advances during the past 10 years. The all but unanimous view endorses the concept of brain death. . . . We recognize the authority of, and indeed encourage, the General Assembly to pronounce statutorily the standards by which death is to be determined in Colorado. We do not, however, believe that in the absence of legislative action we are precluded from facing and resolving the legal issue of whether irretrievable loss of brain function can be used as a means of detecting the condition of death. Under the circumstances of this case we are not only entitled to resolve the question, but have a duty to do so. To act otherwise would be to close our eyes to the scientific and medical advances made worldwide in the past two or three decades.]

Similar cases have arisen in Wisconsin, Massachusetts, New
No case has been found in which the concept of brain death has been rejected.20

State legislatures began considering the issue even before these judicial developments occurred. In 1970, Kansas became the first state to pass a brain-death statute, and Maryland soon adopted a nearly identical provision.21 The Kansas version reads as follows:

A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous respiratory and cardiac function and, because of the disease or condition which caused, directly or indirectly, these functions to cease, or because of the passage of time since these functions ceased, attempts at resuscitation are considered hopeless; and, in this event, death will have occurred at the time these functions ceased; or

A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous brain function; and if based on ordinary standards of medical practice, during reasonable attempts to either maintain or restore spontaneous circulatory or respiratory function in the absence of aforesaid brain function, it appears that further attempts at resuscitation or supportive maintenance will not succeed, death will have occurred at the time when these conditions first coincide. Death is to be pronounced before any vital organ is removed for purposes of transplantation.

These alternative definitions of death are to be utilized for all purposes in this state, including the trials of civil and criminal cases, any laws to the

17 See In re Bowman, 94 Wash. 2d 407, ___, 617 P.2d 731, 736-38 (1980).
18 See In re Children's Hosp., No. 49143 (Minn. Sup. Ct. 1978).
20 Cf. Douglas v. Southwestern Life Ins. Co., 374 S.W.2d 788 (Tex. Civ. App. 1964). A beneficiary under a life insurance policy sued to recover accidental death benefits (ADB). The policy limited ADB to deaths occurring within 90 days of the accident and, although the decedent did not die until 120 days after the accident, his beneficiary argued that it was only because of "extraordinary medical measures" that he lived beyond the 90-day period. Id. at 793. The opinion did not further describe these medical procedures, and, in fact, it was specifically held "that death did not actually occur until approximately 120 days after the accident." Id. This being so, the case is not seen as a rejection of the brain death criterion; see also Bacchiochi v. Johnson Mem. Hosp., No. 256126 (Conn. Super. Ct., Mar. 13, 1981). In Bacchiochi, a physician who had diagnosed irreversible cessation of all brain function nevertheless refused to disconnect the life support system unless given immunity from prosecution. When the state's attorney would not grant immunity, the patient's family sued to have her removed from the respirator. There ensued four days of wasteful and inane legal hearings following which the judge declined to invoke Connecticut's organ-transplant-related brain death law. Id. at ___; see supra note 11; see also Defining Death, supra note 1, at 145-46.
21 See KAN. STAT. ANN. § 77-202 (Supp. 1983); MD. CODE ANN. art. 43, § 54D (1980).
Since that time, thirty-two other states and the District of Columbia have enacted some form of definition-of-death statute. There are three basic types: (1) those with alternative definitions, such as the Kansas law;\(^2\) (2) those that consider brain function only if artificial "life supports" prevent determination of death by traditional means;\(^3\) and (3) those that ignore the traditional standards and refer to brain function only.\(^4\)

The jurisdictions that have no determination-of-death statute are: Arizona, Delaware, Indiana, Kentucky, Maine, Massachusetts, Minnesota, Nebraska, New Hampshire, New Jersey, New York, North Dakota, Ohio, South Carolina, South Dakota, Utah, and Washington.

Few cases have interpreted these laws. In \textit{State v. Shaffer},\(^5\) the defendant argued that the Kansas provision was unconstitutionally vague because it set forth both the brain death and the traditional death standards, and, also because it bases the determination on "ordinary standards of medical practice." The Supreme Court of Kansas found both arguments to be without merit. It rather summarily dismissed the first, and as to the second it held:

\[\text{there is disagreement within the medical profession as to exactly what}\]


\(^3\) See \textit{Defining Death}, supra note 1, app. C at 120-34. Jurisdictions adopting alternative definitions include: Colorado, The District of Columbia, Kansas, Maryland, Mississippi, Missouri, New Mexico, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, and Wisconsin. Among this group, Colorado, The District of Columbia, Mississippi, Pennsylvania, Rhode Island, Vermont and Wisconsin have adopted the Uniform Determination of Death Act (UDDA). This model law was proposed by the National Conference of Commissioners on Uniform State Laws and has been endorsed by the American Bar Association, the American Medical Association, the American Academy of Neurology, the American Electroencephalographic Society, and the President's Commission. The operative language of the proposal reads: "\[a\]n individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards." \textit{Id.} at 118.

\(^4\) A staff study project of The Catholic Health Association of the United States contains the following comments about the UDDA: "\[t\]his model law is a thoughtful, appropriate, and realistic approach to adopting brain-related criteria to diagnose death, and by requiring cessation of all brain functions it provides a necessary bulwark against euthanasia. We pose no legal or moral objection to the UDDA . . . ." \textit{A. Moraczewski & J. Showalter, supra note 3, at 28.}

\(^5\) See \textit{Defining Death}, supra note 1, app. C, at 120-34. These states include Alabama, Alaska, Florida, Hawaii, Iowa, Louisiana, Michigan, and Texas.

\(^22\) See \textit{Defining Death}, supra note 1, app. C, at 120-34. Examples of this approach are found in Arkansas, California, Connecticut, Georgia, Idaho, Illinois, Montana, Nevada, North Carolina, Oklahoma, Tennessee, West Virginia, and Wyoming.

\(^22\) 223 Kan. 244, 574 P.2d 205 (1977).
tests should be employed to determine death. This, of course, is not unusual within that profession.

'Ordinary standards of medical practice' change as medical knowledge and technology improve. Under the instructions given in this case, it was for the jury to determine whether the medical standards . . . had been met. Much of the testimony presented at trial went to this very point. The attack on the statute for failure to specifically enumerate criteria is held to be without merit.27

As the above discussion indicates, "brain death" (the irreversible cessation of all functions of the entire brain) is now the legal standard in over three-fourths of the states. No court has ever rejected the concept, or given it overwhelming acceptance, none is likely to do so.

When technological advances about two decades ago were beginning to create a "medical-legal fog"28 in this area, "[a] little common sense reflection . . . would have solved the problem and headed off much of the unnecessary debate which followed . . . ."29 The time has at last come to put "brain death" aside as a nonissue and devote more energy to the nearly intractable problems surrounding decisions to withhold or terminate treatment.

III. THE LAW ON TERMINATION OF TREATMENT

The previous section focused on those who are already dead. In this section, the subject will be persons who are clearly alive but for whom death or continued suffering are distinct probabilities. It is important for one to remember this difference, because "[a] balanced view of life and death requires that the dying not be treated as if they were dead, nor the dead as if they were living."30

When brain death has occurred, there is no longer any issue regarding terminating or withholding treatment—the patient is dead and the

30 A. Moraczewski & J. Showalter, supra note 3, at 31. In some circumstances it may be appropriate to make an exception to this general principle. For example, there have been cases in which a pregnant woman has suffered "brain death." If this occurs late enough in the pregnancy, it is possible to sustain the child by artificially maintaining the mother's bodily functions until some or all risk of fetal prematurity has passed. Although the mother will have died at the time brain functions ceased, portions of her body can continue to function sufficiently to provide an acceptable milieu for the baby. See Dillon, Lee, Tronsonle, Buckwald & Foote, Life Support and Maternal Brain Death During Pregnancy, 248 J. A.M.A. 1089, 1089 (1982).
cadaver ought not be treated as if it were alive. On the other hand, should the patient be allowed to die before actual brain death has occurred? This will be the seminal medical-legal question of the 1980s, and, indeed, it has already spawned much litigation.

**Competent Adults**

The classic statement of Judge Cardozo in *Schloendorff v. Society of New York Hospital*31 continues to be the guiding principle when the issue involves competent adults: "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ."32 The principle is based on the concept of battery,33 and it suggests, as a general proposition, that a person has a right to refuse any medical treatment, even if that refusal will mean the omission of life-sustaining medical care.

The rule was stated similarly in *Natanson v. Kline*:34 "[e]very person is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery or other medical treatment. . . . The law does not permit [a physician] to substitute his own judgment for that of the patient. . . ."35

Based upon this general rule, in *Satz v. Perlmutter*36 a competent, 73-year-old adult with a terminal condition who was unable to breathe without a respirator was allowed to refuse treatment. The court asserted that such refusal can be overcome by certain state interests (the interests of preserving life, preventing suicide, protecting innocent third parties, and "preserving the ethical integrity of the medical profession"), but it held those arguments unpersuasive under the circumstances.

*In re Quackenbush*7 involved a 72-year-old patient with gangrene of the legs. The court commented that, "the state's interest . . . in preserving life weakens and the individual's right of privacy grows as the degree of bodily invasion increases and the prognosis dims, until the ultimate point when the individual's rights overcome the state's interest in preserving life."38 The patient was permitted to refuse treatment.

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31 211 N.Y. 125, 105 N.E. 92 (1914).
32 Id. at 129-30, 105 N.E. at 93.
35 Id.
38 Id. at —, 383 A.2d at 789; accord, Palm Springs Gen. Hosp., Inc. v. Martinez, No. 71-12678 (Fla. Cir. Ct. July 2, 1971) (court refused to order treatment that would prolong not reverse dying process); Kirby v. Spivey, 167 Ga. App. 751 (1983) (next of kin have no standing to bring wrongful death suit merely because they were not informed of competent patient's decision to forego treatment); Alexandria Hosp. v. McLellan, Chancery No. 13009
A determination of mental incompetence is necessary to overcome the presumption that the patient is capable of making his or her own decision. The mere fact that most persons would consider the decision irrational is not sufficient, and commitment to a mental institution does not, of itself, establish the patient's incompetence for these purposes.

Cases involving refusal of treatment often arise in the context of Jehovah's Witnesses, whose religious beliefs prohibit receipt of blood transfusions. For example, In re Estate of Brooks involved an adult patient who was not pregnant, had no minor children, and refused to consent to life-saving treatment. Long after it had been involuntarily accomplished, the court held that appointment of a conservator to authorize the transfusion amounted to an infringement of the patient's right to exercise freely her religion.

In In re Osborne, the decision of a 34-year-old man to refuse a transfusion was upheld even though he was the father of two children. The court apparently found persuasive the fact that the man's relatives showed the desire and ability to support the children if their father died. Numerous other cases are in accord with Brooks and Osborne.

In a few cases courts have ordered Jehovah's Witnesses to submit to transfusions because of overriding considerations. In Raleigh Fitkin-Paul


32 Ill. 2d 361, 205 N.E.2d 435 (1965).


See, e.g., In re Milideo, 88 Misc. 2d 974, 974-75, 390 N.Y.S.2d 523, 523-24 (Sup. Ct. Suffolk County 1976) (competent 23-year-old without minor children has right to refuse treatment); Erickson v. Dilgard, 44 Misc. 2d 27, 28, 252 N.Y.S.2d 705, 706 (Sup. Ct. Nassau County 1962) (adult has right to refuse transfusion even if it is tantamount to suicide).

In Holmes v. Silver Cross Hosp., 340 F. Supp. 125, 134-35 (N.D. Ill. 1972), a lawsuit was filed by a patient's administratrix under the Civil Rights Act of 1871. She alleged the Act had been violated when the hospital and doctors, after waiting for the patient to lose consciousness, gave a blood transfusion to the decedent even though the patient had refused to consent on religious grounds. Id. at 129. A conservator appointed to authorize the transfusion was also named as a defendant. The court held that the action survived the death of the decedent, the complaint adequately alleged a deprivation of constitutional rights, the conservator shared the judicial immunity of the magistrate who appointed him, the alleged actions of the hospital were "under color of state law," and the alleged actions of the doctors as agents and joint participants with the hospital rendered them liable under the Civil Rights Act, id. at 129-31, 134-35.
Morgan Memorial Hospital v. Anderson, the court ordered blood to save the life of a pregnant woman and her child. And, in the often criticized case of Application of the President and Directors of Georgetown College, Inc., the fact that the patient was the mother of small children seems to have been a consideration. These decisions can perhaps be justified on the basis of the state's legitimate interest in protecting the rights of innocent third parties. In some cases, however, transfusions were ordered simply on the basis of a desire not to let the patient die, irrespective of the patient's wishes and without sound legal analysis supporting the court order.

Whether the patient's decision directly involves religious beliefs or simply reflects a desire to let the dying process take its natural course without burdensome or futile medical interference, it is submitted that a judicial confrontation frequently could and should be prevented.

For example, in Foster v. Tourtellotte, a patient in a Veterans Ad-

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331 F.2d at 1008. The Georgetown College decision was discussed at some length in Brooks:

the Georgetown College case was an altogether unique proceeding in which a single Federal Court of Appeals judge entered an order allowing a blood transfusion to an adult member of Jehovah's Witnesses. A doctor and hospital authorities had appeared originally before a Federal district judge and orally requested entry of an order permitting blood transfusions to be administered to a patient evidently in extremis. The request was denied. Later that same day, an 'appeal' was taken to a single Court of Appeals judge, and the same order was requested of him. In reaching his determination, the judge went to the hospital and spoke with the patient and her husband. The husband said that while his wife was obliged to "abstain from blood," if the court ordered a transfusion, the matter would be out of his hands. The patient stated that the transfusion would be against her will, but she also intimated that the court could take the matter from her hands. The judge then entered the order, determining to 'act on the side of life.'

In subsequently denying a petition for rehearing en banc, the opinions filed by other members of that court indicate their misgivings regarding the substantive and procedural aspects of the action taken. Contrary to appellee's interpretation, we read the opinions as suggesting a majority of the court would have refused the order. However, irrespective of the merits of that case, it is readily distinguishable from the instant one. There, the person alleged to be in extremis was the mother of minor children. The State might well have an overriding interest in the welfare of the mother in that situation, for if she expires, the children might become wards of the State.

32 Ill. 2d at ___, 205 N.E.2d at 439-40.
See 32 Ill. 2d at ___, 205 N.E.2d at 439-40.
ministration hospital suffered from amyotrophic lateral sclerosis, the degenerative and ultimately fatal central nervous system condition commonly known as “Lou Gehrig’s disease.” Although competent, the patient required the assistance of a respirator to breathe. Because this treatment was prolonging his suffering and offered no hope of a cure, he requested numerous times that the device be disconnected. Based on the VA district counsel’s advice, however, the hospital refused the request, thus creating an unnecessary impasse and elevated to the legal arena what ought to have been a private judgment by the patient based on professional medical advise.

After a year delay from the time the patient first requested that the respirator be turned off, the court held: (1) the patient had a legal right to refuse to consent to further use of the machine; (2) its continued use after his request for its discontinuance amounted to an invasion of privacy; (3) removing the respirator would not be euthanasia and would not be assisting suicide; and (4) the plaintiff’s family has no standing to object to his decision.

The order to disengage the life support system was stayed for 15 days until the VA (not yet satisfied with the court’s reasonable approach) could appeal the decision. In the meantime, however, the patient went into a coma and died (as judged by absence of brain function). Finally, on this basis, the stay was dissolved and the respirator was turned off.

Typical of the foggy thinking that often underlies such controversies is the following statement concerning Foster in a national health law newsletter: “Two days after he was declared legally brain dead . . . the plaintiff’s life-support machine was disconnected and he died shortly thereafter.” In truth, the patient had died before the respirator was turned off. He died when his brain ceased to function. Such comments reflect a complete misunderstanding of “brain death” and serve to perpetuate confusion in this field.

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81 See supra note 6 and text accompanying note 7.
82 See also In re Yoder, Civ. No. 81-2690, (Cir. Ct., Cabell County, W. Va., Aug. 31, 1981), reported in __ NAT’L HEALTH LAWYERS ASS’N HEALTH L. DIGEST __ (198-). According to the newsletter report, Golda Yoder, a 76 year old widow, was suffering from cirrhosis of the liver. She had asked the physicians to disconnect life support equipment and permit her to die peacefully. Her seven children were divided on the question, and six of them went to court to prevent the hospital from “pulling the plug.” One daughter wanted the equipment turned off and said she could not understand why her brothers and sisters did not want her mother’s wish granted. The judge said he was torn by the request, and he visited the patient to hear her pleas for relief from suffering. The patient was swollen with fluid, physicians said she had no chance of recovery, and she lapsed into semi-consciousness following the judge’s visit. During a hearing in county court, the physicians passed the judge a message that the patient had just suffered “brain death.” Upon being informed of this, the dissenting children withdrew their petition for a permanent injunction against terminating the life sup-
MEDICAL TREATMENT DECISIONS

It is unfortunate and inhumane to require legal proceedings and their unavoidable delay, expense, and anxiety to obtain judicial sanction of what ought to remain a private matter. In most of these cases there is no real controversy; the patient, the family, the physicians, and the hospital usually agree that the medical treatment would merely prolong the inevitable process of imminent death and should be terminated. But pusillanimity, unreasonable fear of liability, or confusion over applicable standards often lead to litigation. In the end, the litigation only confirms what common sense should have dictated at the outset.

Ethical scholars agree that when treatment would be excessively burdensome to the patient or would offer no reasonable hope of benefit, it may properly be withheld or terminated. It is submitted that in such situations judicial proceedings are disruptive and counterproductive. It is hoped that the example of seeking a court order whenever one of these situations arise will not be perpetuated.

Once-Competent Adults

When incompetent adults who once were competent are the subjects of judicial decisions, courts have shown a tendency to give great weight to the patients' previously expressed wishes. Thus, in the landmark decision in In re Quinlan, the Supreme Court of New Jersey held the right of privacy is "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances." The court found that no external interests of the state justified denying Karen Quinlan's and her family's desire that the respirator be disconnected when no hope of recovery existed.

To quote the newsletter: the judge "granted the patient's wish but only after being informed by her physician that she was already 'brain dead.' She died [sic] nine minutes after the plug on the respirator that continued her ability to breathe was pulled."

See, e.g., Connery, Prolonging Life: The Duty and Its Limits, in MORAL RESPONSIBILITY IN PROLONGING LIFE DECISIONS 124, 129 (D. McCarthy & A. Moraczewski eds., 1981) [hereinafter cited as MORAL RESPONSIBILITY]. As to ethics in health care generally, see B. ASHLEY & K. O'ROURKE, HEALTH CARE ETHICS 385-92 (1978) (if extraordinary medical means required family should have right to make decision).


Id. at 40, 355 A.2d at 663. The court mandated the establishment of an "Ethics Committee" to review the patient's prognosis and, assuming the committee's concurrence, authorized discontinuance of the respirator. Id. at 55, 355 A.2d at 671-72. Interestingly, notwithstanding the court's order, the physicians and hospital continued to refuse to terminate use of the life-support system; the patient was "weaned" from the respirator gradually over a period of weeks, and, although she is emaciated and in an irreversible coma, she is still
Similarly, in the famous "Brother Fox" case, when the patient (an 83 year old member of a Catholic religious order) had consistently expressed the desire not to be maintained on artificial life support systems, the New York Court of Appeals approved discontinuance of the respirator on which he was being maintained in a permanent "vegetative" state with no reasonable chance of recovering.\(^\text{1}\)

When the patient has never expressed a desire regarding treatment, however, the case is somewhat more difficult. While generally reaching living and breathing on her own.

\(^{1}\) In re Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981). The opinion was a consolidation of two cases of which In re Eichner, the one involving Brother Fox, was the second.

\(^{2}\) See Storar, 52 N.Y.2d at 390-91, 420 N.E.2d at 78-79, 438 N.Y.S.2d at 280-81. Brother Fox had been a member of the Society of Mary for over 66 years. He had no close family and considered his religious order to be his "family" for all practical purposes. His best friend, Father Philip Eichner, was the petitioner.

Brother Fox suffered a cardiac arrest and severe brain damage during surgery, and this episode required his placement on a respirator. When two neurosurgeons confirmed the diagnosis of permanent noncognitive state, Father Eichner petitioned in court for permission to terminate the life support measures. He did this because of Brother Fox's frequent and strong statements that he would not want extraordinary life support measures used for his care. Evidence introduced at trial indicated that Brother Fox "first expressed this view in 1976 when [his] community discussed the moral implications of the celebrated Karen Ann Quinlan case . . . ." Id. 371-72, 420 N.E.2d at 68, 438 N.Y.S.2d at 270. The opinion gave weight to the fact that Brother Fox's expressed wishes were consistent with the Catholic teaching.

These were formal discussions prompted by [the order's] mission to teach and promulgate Catholic moral principles. At that time it was noted that the Pope had stated that Catholic principles permitted the termination of extraordinary life support systems when there is no reasonable hope for the patient's recovery and that church officials in New Jersey had concluded that use of the respirator in the Quinlan case constituted an extraordinary measure under the circumstances. Brother Fox expressed agreement with those views and stated that he would not want any of this 'extraordinary business' done for him under those circumstances. Several years later, and only a couple of months before his final hospitalization, Brother Fox again stated that he would not want his life prolonged by such measures if his condition were hopeless.

Id. at 372, 420 N.E.2d at 68, 438 N.Y.S. 2d at 270. Both the supreme court and the appellate division held that Brother Fox had a common-law right to decline treatment and that his expressed wishes should be honored. In addition, the appellate division held that Brother Fox also had a constitutional right to decline the extraordinary treatment being given to him.

The New York Court of Appeals concurred with the opinions of the two lower courts that the common-law right of every person "of adult years and sound mind . . . to determine what should be done with his own body" was controlling as to Brother Fox. The court specifically refused, however, to reach the constitutional issues "because the relief granted to the petitioner, Eichner, is adequately supported by common law principles." 52 N.Y.2d at 377, 420 N.E.2d at 70, 438 N.Y.S.2d at 273. This summary was adapted, with permission, from the Catholic Health association, 6 LAW REPORTS April, 1981, at 3.
the conclusion that burdensome or futile treatment is not required, courts have struggled mightily with questions of procedure and mechanisms for protecting against abuses in these situations. For example, in *In re Spring*, an end-stage-renal-disease patient had acquiesced in his life-prolonging but unpleasant hemodialysis treatment and had received such treatment for several months before becoming incompetent. His wife and son finally concluded that the treatment was no longer benefiting the patient, so they filed for appointment of a guardian and for an order that treatment be discontinued. The Supreme Judicial Court of Massachusetts held that it was proper to decide that treatment be withheld because the patient probably would have made the same choice. The court also noted, however, that the decisionmaking responsibility should rest with the probate court and should not be delegated to the attending physician or the patient's family. This procedural requirement reaffirmed a 1977 precedent in the case of a retarded adult.

On the other hand, in *In re Dinnerstein*, an intermediate appellate court in Massachusetts held that prior judicial sanction was not necessary to implement a do-not-resuscitate order regarding an elderly, comatose, and terminally ill patient. While the medical and ethical outcome is the same in *Dinnerstein* and *Spring*, the judicial philosophies regarding the role of the courts in making these decisions appear quite different. (Perhaps they can be reconciled, however, by viewing *Spring* as involving arguably beneficial treatment and *Dinnerstein* as not.)

Other jurisdictions have struggled with the procedural considerations. As noted earlier, the *Quinlan* court mandated what it called “ethics committees” to assist in the decisionmaking process, and some states require court approval for any decision to withhold life-saving care. A California court has held that “even incompetent persons have a constitutional right to refuse treatment,” but required the appointment of a guardian in order to carry out that right.

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63 See supra note 57.
65 In re Young, 48 U.S.L.W. 2238, (U.S. Sept. 11, 1979), quoted in Bernstein, *Death with Dignity: Is Judicial Involvement Necessary?*, 56 Hosp. May 1, 1982, 93, at 93. On the other hand, the Attorney General of California has opined that courts do not have the authority to approve the termination of treatment if death will result. Op. Cal. Att'y Gen. No. 81-508 (July 2, 1982).
66 See also *In re Guardianship of Langland*, No. SWP 16078, (Super. Ct., Los Angeles
Irrespective of the procedural aspects of these difficult situations, it appears that the courts are slowly coming to a consensus: treatment that is overly burdensome to the patient and/or would not provide the patient a reasonable hope of benefit is not legally mandated; furthermore, omission of that treatment does not give rise to civil or criminal liability. The burden-benefit rationale can be the subject of much dispute when one attempts to apply it to a particular situation. Nowhere is this better illustrated than in the California case Barber v. Superior Court. 6

In Barber, a patient named Clarence Herbert was on life-support systems because a cardiac arrest had resulted in severe brain damage and a permanent comatose condition. At the request of the family, and with the concurrence of the physicians, the respirator and other life support equipment were removed. When Mr. Herbert continued to breathe but showed no signs of improvement in his condition, the physicians, after consultations with the family, "ordered removal of the intravenous tubes which provided hydration and nourishment." Thereafter, the patient received only comfort care until his death.

The two physicians were charged with murder and conspiracy to commit murder. After a lengthy preliminary hearing, a magistrate in Los Angeles dismissed the charges, but a superior court ordered the complaint reinstated. On petition by the physicians, an appellate court then issued a writ prohibiting further action on the charges.

Commenting at the outset that "a murder prosecution is a poor way to design an ethical and moral code for doctors . . . ," the court narrowed the inquiry to whether, in reference to the definition of murder, the physicians' conduct could be considered "unlawful." Because of the "gap between the statutory law and recent medical developments," it determined that this question must be determined on the basis of medical-ethical standards rather than criminal law principles.

[W]e view the use of an intravenous administration of nourishment and fluid, under the circumstances, as being the same as the use of the respirator or other form of life support equipment.

The prosecution would have us draw a distinction between the use of mechanical breathing devices and mechanical feeding devices such as intravenous tubes. The distinction urged seems to be based more on the emotional symbolism of providing food and water to those incapable of providing for themselves rather than on any rational difference in cases such as

County Cal., Aug. 5, 1980), in which the court appointed the patient's son-in-law conservator of a 66-year-old patient in a persistent "vegetative" state. The conservator was given authority to authorize or refuse to authorize all future medical treatment, with the exception of oxygen and feedings. The court found that the patient would not have wanted to be treated if there was "no reasonable possibility of him ever emerging from his coma."

the one at bench. [Citing the President's Commission Deciding to Forego Life-Sustaining Treatment].

Medical nutrition and hydration may not always provide net benefits to patients. Medical procedures to provide nutrition and hydration are more similar to other medical procedures than to typical human ways of providing nutrition and hydration. Their benefits and burdens ought to be evaluated in the same manner as any other medical procedure.

Evaluating Mr. Herbert's situation in light of the benefits and burdens of the life support systems and intravenous tubes, and holding that there was "no duty to continue treatment, once it has proved to be ineffective," the court concluded that omitting further treatment for Mr. Herbert "was not an unlawful failure to perform a legal duty," and dismissed the charges.

As the court stated, "[t]his case . . . belies the belief expressed by many that such decisions would not likely be subjects of criminal prosecution." However, the ultimate outcome reinforces the conclusion that judicial proceedings are usually an inappropriate way to make these difficult decisions. It is preferable that concerned, conscientious individuals (such as Mr. Herbert's family) be given full medical, ethical, pastoral, and social support and then be allowed to make a choice of treatments in accordance with the patient's wishes or best interests. The judiciary should become involved only when an impasse arises or clear abuses occur.

In summary, the burden-benefit standard is an ethically and legally acceptable norm for currently competent patients and those who once were competent.** While its application in a given case can be difficult,

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** Barber contains a lengthy discussion of some of the ethical principles.

In examining this issue we must keep in mind that the life sustaining technology involved in this case is not traditional treatment in that it is not being used to directly cure or even address the pathological condition. It merely sustains biological functions in order to gain time to permit other processes to address the pathology.

The question by this modern technology is, once undertaken, at what point does it cease to perform its intended function and who should have the authority to decide that any further prolongation of the dying process is of no benefit to either the patient or his family?

A physician has no duty to continue treatment, once it has proved to be ineffective. Although there may be a duty to provide life-sustaining machinery in the immediate aftermath of a cardio-respiratory arrest, there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel.

A physician is authorized under the standards of medical practice to discontinue a form of therapy which in his medical judgment is useless. . . . If the treating physicians have determined that continued use of a respirator is useless, then they may decide to discontinue it without fear of civil or criminal liability. By useless is meant that the continued use of the therapy cannot and does not improve the prognosis for recovery.

Of course, the difficult determinations that must be made under these principles is the point at which further treatment will be of no reasonable benefit to the patient,
greater communication and education among health care professionals

who should have the power to make that decision and who should have the authority to direct termination of treatment.

No precise guidelines as to when or how these decisions should be made can be provided by this court since this determination is essentially a medical one to be made at a time and on the basis of facts which will be unique to each case. If specific procedural rules are to be adopted in this area in order to protect the public interest, they must necessarily come from that body most suited for the collection of data and the reaching of a consensus—the Legislature. However, we would be derelict in our duties if we did not provide some general guidelines for future conduct in the absence of such legislation.

'There must be a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgements for the well-being of their dying patients. We would hope that this opinion might be serviceable to some degree in ameliorating the professional problems under discussion.'

Several authorities have discussed the issue of which life-sustaining procedures must be used and for how long their use must be maintained in terms of ‘ordinary’ and ‘extraordinary’ means of treatment. The use of these terms begs the question. A more rational approach involves the determination of whether the proposed treatment is proportionate or disproportionate in terms of the benefits to be gained versus the burdens caused.

Under this approach, proportionate treatment is that which, in the view of the patient, has at least a reasonable chance of providing benefits to the patient, which benefits outweigh the burdens attendant to the treatment. Thus, even if a proposed course of treatment might be extremely painful or intrusive, it would still be proportionate treatment if the prognosis was for complete cure or significant improvement in the patient's condition. On the other hand, a treatment course which is only minimally painful or intrusive may nonetheless be considered disproportionate to the potential benefits if the prognosis is virtually hopeless for any significant improvement in condition.

Several authorities have struggled with this issue and some consensus has been reached on the theory if not the terminology.

'One would have to think that the use of the same respirator or life support system could be considered ‘ordinary’ in the context of the possibly curable patient but ‘extraordinary’ in the context of forced sustaining by cardio-respiratory processes of an irreversibly doomed patient.'

Thus, the determination as to whether the burdens of treatment are worth enduring for any individual patient depends on facts unique to each case, namely, how long the treatment is likely to extend life and under what conditions. 'So long as a mere biological existence is not considered the only value, patients may want to take the nature of that additional life into account as well.'

Of course, the patients interests and desires are the key ingredients of the decision making process. When dealing with patients for whom the possibility of full recovery is virtually non-existent, and who are incapable of expressing their desires, there is also something of a consensus on the standard to be applied.

'The focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence ...'

'Prolongation of life,' ... does not mean a mere suspension of the act of dying,
MEDICAL TREATMENT DECISIONS

should help to minimize the inclination to seek prior judicial sanction in every case.

Children and the Handicapped

Cases involving whether, and if so how, to treat adults are difficult enough, but when the patient is a minor another set of conflicting considerations enters the picture.

As a general rule, a zone of privacy surrounds the parent-child relationship such that parents have considerable freedom in how they raise their children and control their lifestyles.** But when the health or well-being of children is involved, courts have sometimes intervened to order corrective or life-saving therapy, even in the face of the parents' (and sometimes the child's) objections.

The children of Jehovah's Witness parents are often the subject of court-ordered treatment,^6 apparently on the theory that the state's inter-

but contemplates, at the very least, a remission of symptoms enabling a return towards a normal, functioning, integrated existence.'
Id. at —, 195 Cal. Rptr. at 490-92. For additional ethical considerations, see supra note 53. The Barber court also expressly rejected the contention that judicial approval must be sought in all cases:
While guardianship proceedings might be used in this context, we are not aware of any authority requiring such procedure. . . .
In the absence of legislation requiring such legal proceedings, we cannot say that failure to institute such proceedings made petitioners' conduct unlawful. . . .
Under the circumstances of this case, the wife was the proper person to act as surrogate for the patient with the authority to decide issues regarding further treatment, and would have so qualified had judicial approval been sought. There is no evidence that there was any disagreement among the wife and children. Nor was there any evidence that they were motivated in their decision by anything other than love and concern for the dignity of their husband and father.
Furthermore, in the absence of legislative guidance, we find no legal requirement that prior judicial approval is necessary before any decision to withdraw treatment can be made.


In Jehovah’s Witnesses in the State of Washington v. King County Hosp. Unit No. 1, 278 F. Supp. 488 (W.D. Wash. 1967), aff’d, 390 U.S. 598 (1968), a group of Jehovah’s Witnesses challenged the practice of involuntarily administering blood transfusions—as apparently had been done in the past, and, it was alleged, would be done in the future—as a violation of their constitutional rights. A three-judge district court dismissed the case and held that Washington statutes empowering state judges to declare children to be dependents
est in life overrides the parents' right to exercise their religion, at least when this would be to the child's detriment and would deprive the child of an ability to determine his own beliefs upon reaching the age of majority. Jehovah's Witnesses, however, are not the only parties in cases ordering treatment. For example, in Custody of a Minor, a Massachusetts court ordered that a young leukemia patient be removed from his parents' custody and that chemotherapy, to which the parents objected, be instituted. The court commented that although parents have much power to make decisions about their children's lives, their autonomy is not absolute, and the private realm of family life can be entered by the judiciary when a parental decision jeopardizes a child's safety. The court specifically found that the right to control and nurture children carries the correlative duty to care for them and protect them from harm. Similarly, in Maine Medical Center v. Houle, a court intervened under the parens patriae doctrine to order life-saving surgery for a handicapped newborn. The child was retarded and had a congenital defect that prevented normal feeding and breathing. In ordering the corrective treatment, the court found that the parents' decision to refuse surgery (and thus to let the child die) constituted neglect. In numerous other cases courts have ordered treatment for a variety of conditions.

for the purpose of authorizing blood transfusions against the express objections of the parents were not invalid under the U.S. Constitution.

71 For cases involving the distinction between beliefs and exercise, see, e.g., Torcaso v. Watkins, 367 U.S. 488 (1961); Cantwell v. Connecticut, 310 U.S. 296 (1940); Mormon Church v. United States, 136 U.S. 1 (1890); see also L. Manning, The Law of Church-State Relations 251-96 (1980).


75 See, e.g., In re McNulty, No. 1960 (Mass. Probate Ct., Essex County, Feb. 15, 1978); In re Daniels, No. --- (Cir. Ct., Juv. Div., Miami, Fla. July ---, 1981); see also Deciding, supra note 74, at 216.
The authorities are by no means unanimous. In 1979, a California court refused to order corrective heart surgery for a 12-year-old Down's syndrome child even though he did not know his parents and they had shown no interest in his welfare since shortly after his birth. Four years later, following the petition of the child's "psychological parents" to become his guardians, the court held: (1) the evidence was sufficient to sustain the findings that the plaintiffs had become his de facto parents; (2) that his natural parents' retention of custody would continue to cause serious detriment to him; (3) that his best interests would be served by an award of custody to the plaintiffs; and (4) that cardiac catheterization and corrective surgery could be authorized by the new guardians. Other cases in which permission to order treatment against parents' wishes was denied involved surgery for curvature of the spine, a congenital arm deformity, and cleft palate. Distinctions can perhaps be drawn on the basis of the nonemergency nature of the conditions involved in these cases, yet the same cannot be said of In re Infant Doe.

The Infant Doe case has become the subject of a nationwide debate that typifies the lack of consensus within society on these difficult issues. The patient was a newborn Down's syndrome infant who, in addition to the retardation that accompanies Down's syndrome, had a congen-
ital defect that, as in *Houle*, prevented the normal intake of food and liquids. At the request of his parents, and with the concurrence of the mother's obstetrician (although reportedly contrary to the advice of pediatricians), the parents refused to consent to corrective surgery and directed that the baby not be given fluids or nourishment in any manner. Despite furious legal maneuverings by a local prosecutor, right-to-life groups, and numerous individuals who offered to adopt the child, the Indiana courts refused to order surgery and also refused to direct that the baby be nourished and hydrated. The child died six days after his birth.88

As a direct result of *Infant Doe*, the Federal Government sent a notice to all health care providers reminding them that the failure to feed or care for handicapped infants may be a violation of Federal law.89 In addition, the United States Department of Health and Human Services has issued regulations that require health care providers who treat infants to post a notice advising of the requirements of Federal law and of the availability of a toll-free “hotline” telephone number for reporting perceived abuses of the rights of handicapped infants. These developments have generated both a storm of protest from medical organizations and a degree of support from others, however, the survival of the regulations is in doubt at this writing.

In addition to the controversy surrounding the treatment of handicapped infants, the care of retarded adults remains a conundrum. Because these patients have never been competent to express their desires, the courts seem to view them as children and thus intervene to order treatment that is medically efficacious even though many competent persons might quite reasonably (and legally) decide to refuse the same treatment.

*Superintendent of Belchertown State School v. Saikewicz*87 involved an institutionalized 67 year old, profoundly retarded man suffering from incurable leukemia. Physicians proposed that he undergo chemotherapy treatments because it might afford him a brief remission in the progress of the disease. The treatment was both unpleasant and painful, and the patient's guardian ad litem concluded that it would be in the patient's best interest to forgo further medications. The Supreme Judicial Court of Massachusetts agreed:

> [t]here is a substantial distinction in the state's insistence that human life

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89 Deciding, *supra* note 74, at 467-68.
be saved where the affliction is curable, as opposed to the state interest where, as here, the issue is not whether but when, for how long, and at what cost to the individual [his] life may be briefly extended. 

_In re Storar_ involved a terminally ill, profoundly retarded adult cancer patient. His guardian asked for permission to discontinue blood transfusions that compensated for hemorraging at the tumor site. The treatment did not involve what most people would consider excessive pain. The New York Court of Appeals held that discontinuance of the transfusions was improper in light of the fact that with them the patient was functioning at his usual level of mental and physical activity, whereas such level would not have been possible if the treatment had been discontinued. The court analogized the transfusions to food; while they would not cure the cancer, they were intended to “eliminate the risk of death from another treatable cause.” Though the patient did not like the treatments, the court concluded that they were not in and of themselves an extraordinary burden. When blood was given, the patient “was essentially the same as he was before except of course [that] he had a fatal illness which would ultimately claim his life.” The court also commented that, “[a] court should not in the circumstances of this case allow an incompetent patient to bleed to death because someone, even someone as close as a parent or sibling, feels this is best for one with an incurable disease.”

One may quarrel with the differing outcomes of _Saikewicz_ and _Storar_, but the two courts are at least consistent in their definition of the applicable standard. Both courts eschewed such unnecessary fictions as an incompetent’s right of privacy or presumed wishes. They chose instead to weigh the benefit and burden of the proposed medical treatment and to require it if medically necessary. Other jurisdictions should adopt this common sense approach.

**Do-Not-Resuscitate Orders**

Physicians’ orders not to resuscitate patients deserve special mention. It has become customary medical practice to institute cardio-pulmonary resuscitation (CPR) whenever a patient suffers cardiac arrest. Originally, this procedure was intended to avoid a person’s sudden and unexpected death, as, for example, in the case of a heart attack or acci-

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**Footnotes**

88 Id. at ___., 370 N.E.2d at 425-26.
90 Id. at 381-82, 420 N.E.2d at 72, 438 N.Y.S.2d at 275.
91 Id.
92 Id.
93 Id. at 382, 420 N.E.2d at 72-73, 438 N.Y.S.2d at 275-76.
dent." More recently, however, the procedure has become accepted for use on all patients unless the physician has specifically ordered otherwise. Thus, CPR is often attempted even though death is imminent, expected, and unavoidable. In some cases, terminally-ill patients have been resuscitated numerous times before finally succumbing.

In response to such futile, unnecessary, and inhumane use of medical resources, physicians have begun to issue do-not-resuscitate (DNR) orders that alert nurses and other physicians that CPR is not appropriate for the patient. While the DNR order has sometimes been questioned, its legality has been upheld. In the only known case to invalidate a DNR order, Hoyt v. St. Mary's Rehabilitation Center, a peculiar set of circumstances caused the court to conclude that the order was inappropriate as to the particular patient. But the court did not appear to question the propriety of DNR orders generally.

The President's Commission concluded that because the legal authority is somewhat sparse on this issue, "[i]mprovements in this situation probably depend on clarification of the underlying standard of socially accepted medical practices for decisions to forgo resuscitation."

It is not clear, however, why the issues surrounding DNR should be treated any differently than those involving decisions to forgo other forms of medical treatment. As shown above, many courts agree that withholding treatment can be appropriate. When decisionmaking in this area reflects "true respect for the spiritual and physical dignity of patients," the DNR order should be as legally proper as, for example, the decision in Saikewicz to forgo chemotherapy.

In the words of the President's Commission, "[i]f hospitals ensure that decisionmaking practices are reasonable and that internal review and advice are readily available, decisions concerning resuscitation will seldom need to come before courts." The Commission added:

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83 See generally Deciding, supra note 74, at 231-38.
84 Personal knowledge of the author. CPR is not without trauma: "[m]any of the procedures are obviously intrusive, and some are violent in nature. The defibrillator, for example, causes violent (and painful) muscle contractions which . . . may cause fracture of vertebrae or other bones." In re Dinnerstein, 380 N.E.2d 134, 136 (Mass. App. Ct. 1978).
85 See, e.g., Levin & Levin, DNR: An Objectionable Form of Euthanasia, 3 SPECIALTY L. DIGEST: HEALTH CARE, Oct. 1981, at 5. This confusing and poorly reasoned article was written by a physician and a law student.
86 See, e.g., In re Dinnerstein, 380 N.E.2d at 139.
87 Reported in Deciding, supra note 74, at 238 n.29.
88 Id. at 239.
89 See supra notes 32-54 and accompanying text.
90 L. Reilly, Prolonging Life Conscience Formation, in MORAL RESPONSIBILITY supra note 53, at 139.
91 Deciding, supra note 74, at 252.
[i]n states and localities in which prosecutors have indicated that they do not condone DNR orders and that they might bring criminal charges against physicians or hospitals that use such policies, the public, as well as health care professionals and institutions, should defend the practice and make it clear that nonresuscitation is being used thoughtfully and correctly.103

In summary, a DNR order can be an ethically103 and legally appropriate option with respect to people for whom resuscitation would not be a benefit, or for whom it would be an unreasonable burden. Persons who disagree often cite a danger of liability to support their decisions to resuscitate. This argument is unfounded. An omission cannot result in liability unless there was a duty to act. Since the law adopts as its benchmark the standards of the medical profession, the legal system will accept a sound medical-ethical judgment not to resuscitate. A hysterical reaction to the possibility of litigation should not be allowed to conceal this fact.

Written Directives

In all cases, the competent expression of a patient's desires regarding treatment has been given considerable if not conclusive weight.104 This fact led to the emergence of the so-called "living will," which is not binding, and the passage in some states of a "durable power of attorney" or "natural death act" statute. Such developments are discussed in the President's Commission's report,105 and they have been chronicled voluminously elsewhere.106 We will not consider them at length here. It is sufficient to say that these are attempts to give effect to a competent patient's expression of his or her wishes, and authorities of all disciplines seem to agree that those wishes should be carried out absent extraordinary overriding circumstances.107 To quote again from the President's Commission:

[t]he Commission commends the use of advance directives. Health care professionals should be familiar with their state's legal mechanisms for implementing advance directives on life-sustaining treatment and encouraging patients to use these resources. In particular, practitioners can alert patients

103 Id. at 253.
104 See generally B. ASHLEY & K. O'ROURKE, supra note 53, at ___; MORAL RESPONSIBILITY supra note 53, at ___.
105 See supra text accompanying notes 56-59.
107 See, e.g., Deciding, supra note 74, at ch. 4. "In general, a person's choices regarding care ought to override the assessments of others about what best serves that person." Id. at 121.
to the existence of durable power of attorney devices (in states where they exist) and urge them to discuss their desires about treatment with a proxy decisionmaker. In states without applicable legislation, practitioners can still inform their patients of the value of making their wishes known, whether through a living will or more individual instructions regarding the use of life-sustaining procedures under various circumstances.\textsuperscript{108}

Caution must be exercised to ensure that written directives and any statutes that give them binding effect cannot be abused in such a way as to permit euthanasia. Numerous commentators have warned of such dangers.\textsuperscript{109} With that caveat in mind, however, a patient’s written directive is a valuable tool for determining the dividing line between curing the sick and merely caring for the dying.

\textit{Summary of the Law}

In retrospect, the law regarding termination or withholding of treatment is not so confused or unreasonable as some would claim.\textsuperscript{110} For the most part the courts have taken a cautious and reasonable approach to the issues. Although there is some variation as to whether prior judicial approval is required and what surrogates will be allowed to speak for the patient, there is little question about the standard to be applied. A patient’s competent expression of treatment desires usually should be respected. When there is no indication of the patient’s wishes, the decision turns on an analysis in which the benefit to be gained by treatment is weighed against the burdens that the treatment may cause.

This has long been the approach in much of the medical profession.

For example the practice of writing no code orders or of giving them verbally has existed for years. The practice carries no malevolent overtones. It is a matter of professional judgment of those giving the order that further efforts at CPR will serve no medical purpose. The practice represents an abandonment of the medical ethic that life must be sustained, even artificially, at whatever cost, forever. But the abandonment has been forced on the medical profession by the emerging technology which creates the capacity to do just that, i.e.—to artificially maintain pulse and respiration indefinitely.\textsuperscript{111}

The law has come to the same conclusion that medicine and society

\textsuperscript{108} Deciding, supra note 74, at 153.
\textsuperscript{109} See, e.g., INFANTICIDE supra note 82, at —; Nesbitt, Terminating Life Support for Mentally Retarded, Critically Ill Patients: The Prosecutor’s Perspective, 3 J. LEGAL MED. 245 (1982).
\textsuperscript{110} See, e.g., Rosenberg, Pulling the Plug: Could You Be Charged With Murder?, 60 MED. ECON. 84 (1983).
\textsuperscript{111} Clarke, The Choice to Refuse or Withhold Medical Treatment: The Emerging Technology and Medical-Ethical Consensus, 13 CREIGHTON L. REV. 785, 833 n.197 (1980).
are approaching; namely, that it is not always necessary to employ every available treatment to postpone death. There are occasions when it respects life more to let it go than to cling tenaciously to it.

Skeptical health care professionals may nevertheless quite legitimately counter that this is all well and good as a general proposition, but that it makes decisionmaking no less difficult or precarious in the individual case. This is true. In the concluding segment of this Article are some recommendations for addressing that concern.

IV. THE PREFERRED MEDICAL-LEGAL APPROACH

At the end of The Tragedy of King Lear, the Earl of Kent comments on the king's death: “Vex not his ghost. O, let him pass! He hates him that would upon the rack of this tough would stretch him out longer.”

Attorneys, courts, and health care providers would profit from remembering those words. They convey a basic sense of patient autonomy in decisionmaking and the lack of an absolute duty to treat in all cases. Unfortunately, too often these principles are overshadowed by a misunderstanding of legal concepts and the functions of the judicial system. The physician wants immunity from prosecution or civil liability. The patient wants relief from suffering. The family may want the same or may (in the rare case) want to hasten the moment of death for their own reasons. The hospital and the nurses are caught in the middle. Confusion reigns. Communication breaks down and impasse is reached. The parties seek legal counsel, each of whom is primarily concerned with protecting his or her client. Someone goes to the civil court or, worse, calls the criminal authorities. There is little wonder that a well-reasoned decision is not achieved in such a volatile atmosphere.

A classic example of this scenario is found in Bacchiochi v. Johnson Memorial Hospital. Even though Melanie Bacchiochi was dead, the physician would not turn off the respirator without a promise of immunity from prosecution. The district attorney refused to make such a promise, and the patient's family were forced to seek a court order. The court, however, felt the question was a private matter “best determined by the family, by the attending physicians and by the hospitals involved . . . .” The court refused to order the respirator turned off, and there the matter stood until the prosecutor finally agreed, for the one case only, that no prosecution would result. Barber v. Superior Court, discussed
above, was a similarly needless confrontation.\textsuperscript{116} In each of these cases
the reasonable, legal course of action was not taken at least in part because
of a misplaced fear of the judicial system. Ironically, the parties were em-
broiled in a far worse legal battle than they would have been had they fol-
lowed their good medical judgment without regard to legal ramifications.
But because of a misunderstanding of and apprehension about the law and
the judicial system, the actors caused law to be a problem it was not int-
tended to be and sought from it a remedy it ought not to have been asked
to provide.\textsuperscript{117}

When it is necessary to prevent active euthanasia or child abuse and
neglect, for example, recourse to the legal system should not be avoided.
But most decisions to forego life-prolonging treatment do not involve
such macabre considerations. Most involve patients whose conditions are
hopeless and for whom treatment would be futile. The proper response to
the many questions in this area lies in education, communication, and
preventive law. This is so for the following reasons:

(1) the law will support a decision not to give a patient treatment that
would be futile or excessively burdensome; (2) the law will support discon-
tinuing a respirator on a patient whose entire brain has irreversibly ceased
to function; (3) the law recognizes that in some situations reasonable minds
can differ, and so will defer to a well-reasoned medical-ethical decision that
stems from free and open communication among all persons concerned; and
(4) the best legal approach is to be prepared for such situations.\textsuperscript{118}

The first two points were discussed earlier in this Article, but the third
and fourth require some explanation.

Each patient is different. Each has his or her own attitudes toward
serious illness, his or her own emotional and spiritual needs, his or her
own temporal obligations, his or her own tolerance for suffering. What
may seem beneficial to one may be overly burdensome to another. Medi-
cal treatment cannot, therefore, be classified a priori as "ordinary" or
"extraordinary," "obligatory" or "nonobligatory."\textsuperscript{119} The decision must be
made by or for each person based on a thorough consideration of all the
facts of the case and with the patient's wishes or best interests foremost
in mind. When this is done, little danger of liability will attach.

\textit{In re Spring}\textsuperscript{120} supports this conclusion. The court stated that legal
precedent "suggests that the doctor will be protected if he acts on good

\textsuperscript{116} See also \textit{In re} Lydia E. Hall Hospital, 116 Misc. 2d 477, 488, 455 N.Y.S.2d 706, 713 (Sup.
Ct, Nassau County 1982).

\textsuperscript{117} J. Showalter & B. Audrew, \textit{To Treat or Not To Treat} — (1984).

\textsuperscript{118} Id.

\textsuperscript{119} B. Ashley & K. O'Rourke, \textit{supra} note 53, at 382-85; see also Deciding, \textit{supra} note 74, at
4.

\textsuperscript{120} 380 Mass. 629, 405 N.E.2d 115 (1980).
When reasonable minds differ, therefore, the perceived constraints of medical and ethical principles actually become emancipators. Examining those principles and discerning their underlying values enable health care providers, patients, and families to apply them according to the dictates of their own consciences. "The process of adhering to those standards and examining the values behind them also gains the physician legal protection. For it is to these standards that the courts look in determining the physician's legal liability."125

The preferred medical-legal approach to terminating-treatment cases, therefore, is to prepare for them long before they arise. "[A]nticipating these problems and establishing operational processes [to deal with them] will greatly reduce the need for court actions."122 Because the issues are primarily medical and ethical in nature rather than legal, their solution depends more on management and communication skills than on legal talents. In the words of the President's Commission, "decision-making about life-sustaining care is rarely improved by resort to courts,"144 and "a process of collaborating and sharing information and responsibility between care givers and patients generally results in mutually satisfactory decisions."125

To help their health care clients reduce the incidence of litigation, attorneys should assist physicians and hospitals to establish an ongoing educational and collaborative process to focus on these difficult questions. This process should educate all members of the health care team in the underlying social, ethical, medical, and legal concepts involved. It should cut through the emotional, empty rhetoric ("death with dignity," "right to die," "right to life," "quality of life," etc.) to address the root issues—how to maximize the patient's well-being—while recognizing basic fairness and the right to self-determination.125 It should enable all inter-

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121 Id. at ___, 405 N.E.2d at 121.
124 Id. at 247.
125 Deciding, supra note 74, at 44.
126 Ethics committees were first judicially mandated by the Quinlan court to confirm diagnosis and prognosis. See In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976). Other possible functions of ethics committees were outlined by the President's Commission.

They can provide a forum for discussing broader social and ethical concerns raised by a particular case; such bodies may also have an educational role, especially by teaching all professional staff how to identify, frame, and resolve ethical problems. They can be a means for formulating policy and guidelines regarding such
ested persons, including patients and families, to become involved. It should include the participation of a standing “ethics committee” for the purpose of being a forum to settle controversies internally. It should produce written hospital policies and procedures dealing with the most common situations.

There is a wide variety of approaches to these prophylactic measures. Each facility and medical staff should jointly build mechanisms for improving their medical-ethical decisionmaking and to free it “from misunderstanding about the dictates of law and morality.” If this can be done, the need and desire to litigate these questions should be greatly reduced.

The recently compiled work of the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research is an invaluable resource in this regard. In slightly over three years, the Commission built consensus on many of these questions. Numerous organizations are moving forward to help the health care field and the general public understand and implement the Commission’s findings. The preferred medical-legal approach is to encourage and lead this ongoing educational effort.

V. Conclusion

This Article began by reviewing the state of the law concerning “brain death.” It is suggested that there is virtual unanimity on the propriety of diagnosing death on the basis of total cessation of all brain functions. It urged the medical and legal professions to regard this question as no longer worthy of debate.

The Article then summarized the most important cases concerning decisions to terminate or withhold medical care. It concluded that although some procedural differences do exist, most notably regarding the necessity of advance judicial approval, the authorities agree that patient preferences should usually be determinative; when the patient’s desires are unknown a decision should be made by weighing the degree of burden it would cause and the benefit it would provide. It is the contention of this Article that this judgment can and should properly be made without judicial involvement; that the courts should be asked to intervene only in

Finally, they can review decisions made by others (such as physicians and surrogates) about the treatment of specific patients or make such decisions themselves. Deciding, supra note 74, at 180-61.

127 Deciding, supra note 74, at 99.
128 Id.
129 See supra note 2. The general conclusions of the President’s Commission regarding decisions to terminate or withhold treatment are set forth in the Appendix.
those infrequent situations in which the criminal law is implicated, for example, when child abuse or euthanasia is suspected.

Finally, the Article strongly suggests that problems in this field stem mostly from poor communication and insufficient education. It encouraged a multi-disciplinary approach that will raise public awareness of the social, ethical, and medical standards that apply to such decisions. As one writer stated,

[t]hese cases arise because of a technology which has outpaced the legal and ethical framework which must cope with it. In the long run these cases must be decided on the basis of accepted medical judgment and practice distinguishing between necessary and unnecessary care and acting on that distinction. The legal and ethical framework now exists. Privately the medical practice frequently exists as well. Ultimately, the law only requires physicians to practice good medicine. In the minds of a growing number of practitioners, life support apparatus such as respirators are not and can not be considered as long term warehousing devices for the terminally ill or vegetative patient but instead are short term therapeutic aids. It is the misuse of this technology, born solely out of concern for liability rather than good medicine, which has created an unwelcome place for lawyers, judges, and legislatures to inject [such issues as consent and right to privacy] into this unfortunate class of cases.\(^\text{130}\)

Medical ethics along the fringes of life involve delicate, emotional, and complex questions. They are best answered by thoughtful, sensitive, well-informed people working together to explore all possible alternatives and arrive at a consensus. This approach is impossible in the confrontational arena of the courtroom. It can and should occur only in the realm of health care itself, the private colloquy of doctor and patient, enhanced by the wise counsel of pastors, ethicists, social workers, and others. As in any area involving human judgment, it is inevitable that some mistakes will be made, even by those acting in good faith. That fact, however, does not justify either medical diffidence or judicial intervention.

\(^{130}\) Clarke, supra note 111, at 838.
APPENDIX

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research

Summary of Conclusions

Building on a central conclusion of its report on informed consent— that decisions about health care ultimately rest with competent patients—the Commission in this Report examines the situations in which a patient's choice to forego life-sustaining therapy may be limited on moral or legal grounds. In addition to providing clarification of the issues, the Report suggests appropriate procedures for decisions regarding both competent and incompetent patients and scrutinizes the role of various public and private bodies in shaping and regulating the process.

These aims are the only ones that this Commission believes to be within the scope of its role. The Report does not judge any particular future case nor provide a guidebook of the morally correct choice for patients and health care providers who are facing such a decision. Rather, the Commission intends to illuminate the strengths and weaknesses of various considerations and various instruments of social policy. Clarifying the relevant considerations and prohibitions may help decisionmakers, but it may also force them to confront painful realities more directly. The Commission hopes that this Report will help improve the process, but recognizes that an improved process will not necessarily make decisions easier.

The Report addresses a broad range of problems and patient situations. Serious questions about whether life should be sustained through a particular treatment usually arise when a patient is suffering from a known disease likely to prove fatal in the near future rather than in an unanticipated emergency (where any decisionmaking would necessarily have to be truncated). Life-sustaining treatment, as used here, encompasses all health care interventions that have the effect of increasing the life span of the patient. Although the term includes respirators, kidney machines, and all the paraphernalia of modern medicine, it also includes home physical therapy, nursing support for activities of daily living, and special feeding procedures, provided that one of the effects of the treatment is to prolong a patient's life.

The issues addressed in this Report are complex and their resolution depends not only on the context of particular decisions but also on their relationship to other values and principles. Thus, it is exceptionally diffi-

MEDICAL TREATMENT DECISIONS

cult to summarize the Commission’s conclusions on this subject. The syn-
opsis provided here should be read in the context of the reasoning, elabor-
ation, and qualifications provided in the chapters that follow.

(1) The voluntary choice of a competent and informed patient should
determine whether life-sustaining therapy will be undertaken, just as
such choices provide the basis for other decisions about medical treat-
ment. Health care institutions and professionals should try to enhance
patients’ abilities to make decisions on their own behalf and to promote
understanding of the available treatment options.

(2) Health care professionals serve patients best by maintaining a
presumption in favor of sustaining life, while recognizing that competent
patients are entitled to choose to forego any treatments, including those
that sustain life.

(3) As in medical decisionmaking generally, some constraints on pa-
tients’ decisions are justified.

• Health care professionals or institutions may decline to provide a
particular option because that choice would violate their conscience
or professional judgment, though in doing so they may not abandon
a patient.

• Health care institutions may justifiably restrict the availability of
certain options in order to use limited resources more effectively or
to enhance equity in allocating them.

• Society may decide to limit the availability of certain options for
care in order to advance equity or the general welfare, but such poli-
cies should not be applied initially nor especially forcefully to medi-
cal options that could sustain life.

• Information about the existence and justification of any of these
constraints must be available to patients or their surrogates.

(4) Governmental agencies, institutional providers of care, individual
practitioners, and the general public should try to improve the medically
beneficial options that are available to dying patients. Specific attention
should be paid to making respectful, responsive, and competent care
available for people who choose to forego life-sustaining therapy or for
whom no such therapy is available.

(5) Several distinctions are employed by health care professionals
and others in deliberating about whether a choice that leads to an earlier
death would be acceptable or unacceptable in a particular case. Unfortu-
nately, people often treat these distinctions—between acts and omissions
that cause death, between withholding and withdrawing care, between an
intended death and one that is merely foreseeable, and between ordinary
and extraordinary treatment—as though applying them decided the issue,
which it does not. Although there is a danger that relying on such labels
will take the place of analysis, these distinctions can still be helpful if
attention is directed to the reasoning behind them, such as the degree to which a patient is benefited or burdened by a treatment.

(6) Achieving medically and morally appropriate decisions does not require changes in statutes concerning homicide or wrongful death, given appropriate prosecutorial discretion and judicial interpretation.

(7) Primary responsibility for ensuring that morally justified processes of decisionmaking are followed lies with physicians. Health care institutions also have a responsibility to ensure that there are appropriate procedures to enhance patients’ competence, to provide for designation of surrogates, to guarantee that patients are adequately informed, to overcome the influence of dominant institutional biases, to provide review of decisionmaking, and to refer cases to the courts appropriately. The Commission is not recommending that hospitals and other institutions take over decisions about patient care; there is no substitute for the dedication, compassion, and professional judgment of physicians. Nevertheless, institutions need to develop policies because their decisions have profound effects on patient outcomes, because society looks to these institutions to ensure the means necessary to preserve both health and the value of self-determination, and because they are conveniently situated to provide efficient, confidential, and rapid supervision and review of decisionmaking.

INCOMPETENT PATIENTS GENERALLY

(8) Physicians who make initial assessments of patients’ competence and others who review these assessments should be responsible for judging whether a particular patient’s decisionmaking abilities are sufficient to meet the demands of the specific decision at hand.

(9) To protect the interests of patients who have insufficient capacity to make particular decisions and to ensure their well-being and self-determination:

- An appropriate surrogate, ordinarily a family member, should be named to make decisions for such patients. The decisions of surrogates should, when possible, attempt to replicate the ones that the patient would make if capable of doing so. When lack of evidence about the patient’s wishes precludes this, decisions by surrogates should seek to protect the patient’s best interests. Because such decisions are not instances of self-choice by the patient, the range of acceptable decisions by surrogates is sometimes not as broad as it

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8 "Decisionmaking guided by the best interest standard requires a surrogate to do what, from an objective standpoint, appears to promote a patient’s good without reference to the patient’s actual or supposed preferences.” MAKING HEALTH CARE DECISIONS, supra note 1, at 179.
would be for patients making decisions for themselves.

- The medical staff, along with the trustees and administrators of health care institutions, should explore and evaluate various formal and informal administrative arrangements for review and consultation, such as “ethics committees,” particularly for decisions that have life-or-death consequences for incompetent patients.

- State courts and legislatures should consider making provision for advance directives through which people designate others to make health care decisions on their behalf and/or give instructions about their care. Such advance directives provide a means of preserving some self-determination for patients who may lose their decision-making capacity. Durable powers of attorney are preferable to “living wills” since they are more generally applicable and provide a better vehicle for patients to exercise self-determination, though experience with both is limited.

- Health care professionals and institutions should adopt clear, explicit, and publicly available policies regarding how and by whom decisions are to be made for patients who lack adequate decision-making capacity.

- Families, health care institutions, and professionals should work together to make decisions for patients who lack decisionmaking capacity. Recourse to the courts should be reserved for the occasions when adjudication is clearly required by state law or when concerned parties have disagreements that they cannot resolve over matters of substantial import. Courts and legislatures should be cautious about requiring judicial review of routine health care decisions for patients with inadequate decisionmaking capacity.

**Patients with Permanent Loss of Consciousness**

(10) Current understanding of brain functions allows a reliable diagnosis of permanent loss of consciousness for some patients. Whether or not life-sustaining treatment is given is of much less importance to such patients than to others.

(11) The decisions of patients’ families should determine what sort of medical care permanently unconscious patients receive. Other than requiring appropriate decisionmaking procedures for these patients, the law does not and should not require any particular therapies to be applied or continued, with the exception of basic nursing care that is needed to ensure dignified and respectful treatment of the patient.

(12) Access to costly care for patients who have permanently lost consciousness may justifiably be restricted on the basis of resource use in two ways: by a physician or institution that otherwise would have to deny significantly beneficial care to another specific patient, or by legitimate
mechanisms of policy formulation and application if and only if the provision of certain kinds of care to these patients were clearly causing serious inequities in the use of community resources.

**Seriously Ill Newborns**

(13) Parents should be the surrogates for a seriously ill newborn unless they are disqualified by decisionmaking incapacity, an unresolvable disagreement between them, or their choice of a course of action that is clearly against the infant's best interests.

(14) Therapies expected to be futile for a seriously ill newborn need not be provided; parents, health care professionals and institutions, and reimbursement sources, however, should ensure the infant's comfort.

(15) Within constraints of equity and availability, infants should receive all therapies that are clearly beneficial to them. For example, an otherwise healthy Downs Syndrome child whose life is threatened by a surgically correctable complication should receive the surgery because he or she would clearly benefit from it.

- The concept of benefit necessarily makes reference to the context of the infant's present and future treatment, taking into account such matters as the level of biomedical knowledge and technology and the availability of services necessary for the child's treatment.
- The dependence of benefit upon context underlines society's special obligation to provide necessary services for handicapped children and their families, which rests on the special ethical duties owed to newborns with undeserved disadvantages and on the general ethical duty of the community to ensure equitable access for all persons to an adequate level of health care.³

(16) Decisionmakers should have access to the most accurate and up-to-date information as they consider individual cases.

- Physicians should obtain appropriate consultations and referrals.
- The significance of the diagnoses and the prognoses under each treatment option must be conveyed to the parents (or other surrogates).

(17) The medical staff, administrators, and trustees of each institution that provides care to seriously ill newborns should take the responsibility for ensuring good decisionmaking practices. Accrediting bodies may

³ "A determination of this [adequate] level will take into account the value of various types of health care in relation to each other as well as the value of health care in relation to other important goods for which societal resources are needed." President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Securing Access to Health Care 4-5 U.S. Government Printing Office, Washington (1983).
want to require that institutions have appropriate policies in this area.

- An institution should have clear and explicit policies that require prospective or retrospective review of decisions when life-sustaining treatment for an infant might be foregone or when parents and providers disagree about the correct decision for an infant. Certain categories of clearly futile therapies could be explicitly excluded from review.
- The best interests of an infant should be pursued when those interests are clear.
- The policies should allow for the exercise of parental discretion when a child’s interests are ambiguous.
- Decisions should be referred to public agencies (including courts) for review when necessary to determine whether parents should be disqualified as decisionmakers and, if so, who should decide the course of treatment that would be in the best interests of the child.

(18) The legal system has various—though limited—roles in ensuring that seriously ill infants receive the correct care.

- Civil courts are ultimately the appropriate decisionmakers concerning the disqualification of parents as surrogates and the designation of surrogates to serve in their stead.
- Special statutes requiring providers to bring such cases to the attention of civil authorities do not seem warranted, since state laws already require providers to report cases of child abuse or neglect to social service agencies; nevertheless, educating providers about their responsibilities is important.
- Although criminal penalties should be available to punish serious errors, the ability of the criminal law to ensure good decisionmaking in individual cases is limited.
- Governmental agencies that reimburse for health care may insist that institutions have policies and procedures regarding decision-making, but using financial sanctions against institutions to punish an “incorrect” decision in a particular case is likely to be ineffective and to lead to excessively detailed regulations that would involve government reimbursement officials in bedside decisionmaking. Furthermore, such sanctions could actually penalize other patients and providers in an unjust way.

CARDIOPULMONARY RESUSCITATION

(19) A presumption favoring resuscitation of hospitalized patients in the event of unexpected cardiac arrest is justified.

(20) A competent and informed patient or an incompetent patient’s
surrogate is entitled to decide with the attending physician that an order against resuscitation should be written in the chart. When cardiac arrest is likely, a patient (or a surrogate) should usually be informed and offered the chance specifically to decide for or against resuscitation.

(21) Physicians have a duty to assess for each hospitalized patient whether resuscitation is likely, on balance, to benefit the patient, to fail to benefit, or to have uncertain effect.

- When a patient will not benefit from resuscitation, a decision not to resuscitate, with the consent of the patient or surrogate, is justified.
- When a physician’s assessment conflicts with a competent patient’s decision, further discussion and consultation are appropriate; ultimately the physician must follow the patient’s decision or transfer responsibility for that patient to another physician.
- When a physician’s assessment conflicts with that of an incompetent patient’s surrogate, further discussion, consultation, review by an institutional committee, and, if necessary, judicial review should be sought.

(22) To protect the interests of patients and their families, health care institutions should have explicit policies and procedures governing orders not to resuscitate, and accrediting bodies should require such policies.

- Such policies should require that orders not to resuscitate be in written form and that they delineate who has the authority both to write such orders and to stop a resuscitation effort in progress.
- Federal agencies responsible for the direct provision of patient care (such as the Veterans Administration, the Public Health Service, and the Department of Defense) should ensure that their health care facilities adopt appropriate policies.

(23) The entry of an order not to resuscitate holds no necessary implications for any other therapeutic decisions, and the level or extent of health care that will be reimbursed under public or private insurance programs should never be linked to such orders.

(24) The education of health care professionals should ensure that they know how to help patients and family make ethically justified decisions for or against resuscitation; those responsible for professional licensure and certification may want to assess knowledge in these areas.